WISCONSIN MEDICAID
PRIOR AUTHORIZATION / CHILD / ADOLESCENT DAY TREATMENT ATTACHMENT (PA/CADTA) COMPLETION INSTRUCTIONS

Wisconsin Medicaid requires information to enable Medicaid to authorize and pay for medical services provided to eligible recipients.

Recipients are required to give providers full, correct, and truthful information for the submission of correct and complete claims for Medicaid reimbursement. This information should include, but is not limited to, information concerning eligibility status, accurate name, address, and Medicaid identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about Medicaid applicants and recipients is confidential and is used for purposes directly related to Medicaid administration such as determining eligibility of the applicant, processing prior authorization (PA) requests, or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of PA or Medicaid payment for the services.

The use of this form is voluntary and providers may develop their own form as long as it includes all the information and is formatted exactly like this form. If necessary, attach additional pages if more space is needed. Providers should refer to the service-specific handbook for service restrictions and additional documentation requirements. Provide enough information for Wisconsin Medicaid medical consultants to make a reasonable judgement about the case.

Attach the completed Prior Authorization/Child/Adolescent Day Treatment Attachment (PA/CADTA), physician prescription, and evidence of a HealthCheck screen to the Prior Authorization Request Form (PA/RF) and send it to Wisconsin Medicaid. Providers may submit PA requests by fax to Wisconsin Medicaid at (608) 221-8616. Providers who wish to submit PA requests by mail may do so by submitting them to the following address:

Wisconsin Medicaid
Prior Authorization
Ste 88
6406 Bridge Rd
Madison WI 53784-0088

GENERAL INSTRUCTIONS

The information contained in this PA/CADTA will be used to make a decision about the amount of child/adolescent day treatment which will be approved for Medicaid reimbursement. Complete each section as completely as possible. **Where noted in these instructions,** the provider may attach material that he or she may have in his or her records.

Initial Prior Authorization Request
Complete the PA/RF and the entire PA/CADTA and attach the HealthCheck referral and physician order. Label all attachments (e.g., “Day Treatment-Treatment Plan”). The initial authorization will be for a period of no longer than three months.

First Reauthorization
Complete the PA/RF and Sections I-III of the PA/CADTA. Attach a physician order for day treatment dated within one year of the date of receipt at Wisconsin Medicaid and a copy of the HealthCheck verification dated within one year of the beginning date of service (DOS) (these may be copies of those included with the initial authorization request). Attach a summary of the treatment to date, and a revised day treatment services treatment plan. Note progress on short- and long-term goals from the original plan. Be explicit in the summary as to the need for continued day treatment services. Authorization will be for a period of no longer than three months.

Second Reauthorization
Complete the PA/RF and Sections I-III of the PA/CADTA. Attach a copy of the physician order for day treatment and a copy of the HealthCheck verification dated within one year of the beginning DOS (these may be copies of those included with the previous authorization requests). Include an updated multi-agency treatment plan and an updated screening (the Achenbach Child Behavior Checklist or the Child and Adolescent Functional Assessment Scale [CAFAS]) using the same screening tool used for the initial request. Summarize the treatment since the previous authorization. The need for continued day treatment must be clearly documented. Where no change is noted in the treatment summary, justify the continued use of day treatment or note how changes in the treatment plan address the lack of progress. Specifically address aftercare planning. Authorization will be for a period of no longer than three months.

Subsequent Reauthorizations
Complete the PA/RF and Sections I-III of the PA/CADTA. Attach a copy of the physician order for day treatment and a copy of the HealthCheck verification dated within one year of the beginning DOS (these may be copies of those included with the previous authorization request). Attach a summary of the treatment since the previous authorization. Address why the recipient has not made transition to aftercare services. Strong justification will be required for day treatment services exceeding nine months per episode of treatment.

Please check the appropriate box at the top of the PA/CADTA to indicate whether this request is an initial, first reauthorization, second reauthorization, or subsequent reauthorization request. Make sure that the appropriate materials are included for the type of request indicated.

Multiple Services
When a recipient will require PA for other services concurrent to the child/adolescent day treatment (e.g., in-home treatment), a separate PA request must be submitted for those services along with the appropriate PA attachment and all required materials. The coordination of these concurrent services needs to be clearly indicated within the clinical documentation for all services. These other services must be identified on the multi-agency treatment plan(s).

SECTION I — RECIPIENT INFORMATION

Element 1 — Name — Recipient
Enter the recipient's last name, followed by his or her first name and middle initial, exactly as it appears on the recipient's Medicaid identification card.

Element 2 — Age — Recipient
Enter the age of the recipient in numerical form (e.g., 16).

Element 3 — Recipient Medicaid Identification Number
Enter the recipient's 10-digit Medicaid identification number exactly as it appears on the recipient's Medicaid identification card.

SECTION II — PROVIDER INFORMATION

Element 4 — Name — Day Treatment Provider
Enter the name of the Medicaid-certified day treatment program which will be billing for the services.

Element 5 — Day Treatment Provider's Medicaid Provider Number
Enter the eight-digit Medicaid provider number for the day treatment provider. Providers will be assigned a unique provider number for the child/adolescent day treatment program.

Element 6 — Name — Contact Person
Enter the name of a person who would be able to answer questions about this request.

Element 7 — Telephone Number — Contact Person
Enter the telephone number of the contact person.

SECTION III — DOCUMENTATION

Element 8
Indicate the date for which the provider wishes services to be first authorized and the end date for the authorization period. See the general instructions for information on the length of authorization that will be generally allowed. If the start date is prior to when this request will be received at Wisconsin Medicaid, clinical rationale must be provided justifying the need to start treatment prior to obtaining authorization. Requests may be backdated up to 10 working days on the initial authorization if this is requested and appropriate rationale is provided.

Element 9
Indicate the total number of hours for which the provider is requesting Medicaid reimbursement for this PA grant period. The total number of hours should equal the quantity requested in Element 20 of the PA/RF.

Element 10
Present or attach a summary of diagnostic assessment and differential diagnosis. Diagnoses on all five axes of the most recent version of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) are required. The assessment should address the level of reality testing, thought processes, drive control, relational capacity, and defensive functioning. If not conducted by a psychiatrist or psychologist,* a psychiatrist or psychologist* must review and sign the summary and diagnosis. In some cases where the only, or primary, diagnosis is a conduct disorder, the request should provide sufficient justification for the appropriateness of day treatment. In those cases where the only, or primary, diagnosis is a psychoactive substance abuse disorder, requests will generally not be approved unless there is sufficient justification for the appropriateness of a mental health day treatment program. **Providers may attach copies of an existing assessment.**

Element 11
If the recipient is on medication, the treatment plan must include the name of the physician managing those medications. Present or attach a summary of the recipient's illness/treatment/medication history. For individuals with significant substance abuse problems, the multi-agency treatment plan should indicate how these will be addressed. **Providers may attach copies of illness/treatment/medication histories that are contained in their records.**

*One who is licensed in Wisconsin and listed, or eligible to be listed, in the national register of health care providers in psychology.

Element 12

a. Complete the checklist for determining that an individual meets the criteria for severe emotional disturbance.

The following information defines the allowable conditions for b. and c. of the checklist.

b. List the primary diagnosis and diagnosis code in the space provided. The individual must have one of the following DSM diagnoses:

Disorders usually first diagnosed in infancy, childhood, and adolescence include:
- Pervasive developmental disorders (coded on Axis II: 299.00; 299.10; 299.80).
- Attention-deficit and disruptive behavior disorders (312.81; 312.82; 312.89; 312.9; 313.81; 314.00; 314.01; 314.9).
- Feeding and eating disorders of infancy or early childhood (307.52; 307.53; 307.59).
- Tic disorders (307.20; 307.22; 307.23) .
- Other disorders of infancy, childhood, or adolescence (307.3; 309.21; 313.23; 313.89).

Adult diagnostic categories appropriate for children and adolescents are:
- Substance-related disorders (303.90; 304.00-304.90; 305.00; 305.20-305.70; 305.90, except not caffeine intoxication).
- Schizophrenia and other psychotic disorders (293.81; 293.82; 295.10-295.40; 295.60-295.70; 295.90; 297.1; 297.3; 298.9).
- Mood disorders (293.83; 296.00-296.90; 300.4; 301.13; 311).
- Anxiety disorders (300.00-300.02; 300.21-300.23; 300.29; 300.3; 308.3; 309.81).
- Somatoform disorders (300.11; 300.81).
- Dissociative disorders (300.12-300.15; 300.6).
- Sexual and gender identity disorders (302.2-302.4; 302.6; 302.89; 302.9).
- Eating disorders (307.1; 307.51).
- Impulse-control disorders (312.30; 312.33; 312.34).
- Adjustment disorders (309.0; 309.24; 309.28; 309.3; 309.4; 309.9).
- Personality disorders coded on Axis II (301.0; 301.20-301.9).

c. Check those boxes that apply. The individual must have one symptom or two functional impairments.

Symptoms

1. Psychoactive symptoms — Serious mental illness (e.g., schizophrenia) characterized by defective or lost contact with reality, often with hallucinations or delusions.
2. Suicidality — The individual must have made one attempt within the last three months or have significant ideation about or have made a plan for suicide within the past month.
3. Violence — The individual must be at risk for causing injury to persons or significant damage to property as a result of emotional disturbance.

Functional Impairments (compared to expected developmental level)

1. Functioning in self care — Impairment in self care is manifested by a person's consistent inability to take care of personal grooming, hygiene, clothes, and meeting of nutritional needs.
2. Functioning in community — Impairment in community function is manifested by a consistent lack of age-appropriate behavioral controls, decision making, judgment, and value system which results in potential involvement or involvement in the juvenile justice system.
3. Functioning in social relationships — Impairment of social relationships is manifested by the consistent inability to develop and maintain satisfactory relationships with peers and adults.
4. Functioning in the family — Impairment in family function is manifested by pattern of significantly disruptive behavior exemplified by repeated and/or unprovoked violence to siblings and/or parents, disregard for safety and welfare of self or others, e.g., fire setting, serious and chronic destructiveness, inability to conform to reasonable limitations, and expectations which may result in removal from the family or its equivalent.
5. Functioning at school / work — Impairment in any *one* of the following:
   a) Impairment in functioning at school is manifested by the inability to pursue educational goals in a normal time frame, such as consistently failing grades, repeated truancy, expulsion, property damage, or violence towards others.
   b) Meeting the definition of "child with exceptional educational needs: under ch. PI 11, Wis. Admin. Code, and s. 115.76(3) Wis. Stats.
   c) Impairment at work is the inability to be consistently employed at a self-sustaining level, such as the inability to conform to work schedule, poor relationships with supervisor and other workers, or hostile behavior on the job.

d. Check those boxes that apply.

The individual is receiving services from two or more of the following service systems

- ❑ Mental health.
- ❑ Social services.
- ❑ Child protective services.
- ❑ Juvenile justice.
- ❑ Special education.

Eligibility criteria waived under certain circumstances:

- ❑ This individual would otherwise meet the definition of SED, but has not yet received services from more than one system, but, in the judgement of the medical consultant, would be likely to do so were the intensity of treatment requested not provided. Attach explanation.
- ❑ This individual would otherwise meet the definition of SED, but functional impairment has not persisted for six months, or the judgement of the medical consultant, the nature of the acute episode is such that impairment in functioning (as defined in the "Severe Emotional Disturbance Criteria Checklist," January 29, 1992) is likely to be evident without the intensity of treatment requested. Attach explanation.

Note: A Substance Abuse Assessment may be included. A Substance Abuse Assessment must be included if substance abuse related programming is part of the recipient's treatment program.

Element 13
Describe the treatment program which will be provided. Participation in specific groups/activities must be justified by the treatment plan. Attach a summary/description of groups or program components. The information presented should be adequate for determining that those services for which reimbursement are requested are Medicaid reimbursable.

Element 14
If not previously addressed, indicate the rationale for day treatment as opposed to other treatment modalities. Where less intensive outpatient (clinic) services have not been provided, discuss why not. Providers should present this justification in their own words and not assume that the consultants can infer this from other materials presented with the request.

Element 15
Indicate the expected duration of day treatment. Describe services expected to be rendered following completion of day treatment and transition plans. While providers are expected to indicate their expectations on the initial request, it is critical that plans for terminating day treatment be discussed in any requests for services at and beyond six months of treatment.

SECTION IV — ATTACHMENTS AND SIGNATURE

Element 16
The following materials must be attached and labeled.

a. The request must include documentation that the recipient had a comprehensive HealthCheck screen within one year of the date the Child/Adolescent Day Treatment Attachment PA request is received at Wisconsin Medicaid. A HealthCheck Referral Form is no longer required for approval of a PA request. A PA request may be considered for approval so long as the PA request includes a statement or indication from the HealthCheck screener that a HealthCheck screen was performed. This must be signed and must show the date of the screen, which must be within one year of the date of receipt of the PA request.

b. Attach a physician's prescription for day treatment services, signed by a physician, preferably a psychiatrist, dated within one year of date of receipt at Wisconsin Medicaid.

c. The treatment team must complete a treatment plan covering their day treatment services. The plan must contain measurable goals, specific methods, and an expected time frame for achievement of the goals. The treatment plan must be tailored for the individual recipient.

The plan must clearly identify how specific program components relate to specific treatment goals. The methods allow for a clear determination that the services provided meet criteria for Medicaid covered services. Services which are primarily social or recreational in nature, educational services, and mealtimes are not reimbursable.

d. The multi-agency treatment plan must be developed by representatives from all systems involved with the recipient (school, juvenile justice, social services, etc.). The plan must address the role of each system in the overall treatment and the major goals for each agency involved. Ideally, the plan should be signed by all participants, but to facilitate submission, the provider may document who was involved. Where some agency was not involved in the planning, the provider must document the reason and what attempts were made to include them. The plan should indicate why day treatment services are necessary and desirable. The individual who is coordinating the multi-agency planning should be clearly identified. A psychiatrist or psychologist* must sign either the multi-agency or day treatment plan (make sure the physician is identified as a psychiatrist). A model multi-agency treatment plan form is available on the forms page of the Wisconsin Medicaid Web site. To access the model plan form, follow these instructions:

1. Go to *www.dhfs.state.wi.us/medicaid.*
2. Choose “Providers” from the options listed in the Wisconsin Medicaid main menu.
3. Select “Provider Forms” under the “Provider Publications and Forms” topic area.

e. Providers must complete and attach the results of either the Achenbach Child Behavior Checklist or the CAFAS. Information about these screening instruments is available on the Internet under “Achenbach Behavior Checklist” and “Child and Adolescent Functional Assessment Scale.”

f. Submit a copy of a Substance Abuse Assessment where the psychiatric assessment indicates significant substance abuse problems and substance abuse-related services will be a part of the day treatment program. The assessment may be summarized in Section II-A of II-B as part of the psychiatric assessment or illness history. If the substance abuse problems will be addressed by some other agency, this should be indicated in the multi-agency treatment plan.

Element 17 — Signature — Day Treatment Program Director (Psychiatrist or Psycholgist*)
The PA/CADTA request must be signed by the day treatment program director (psychologist or psychiatrist*).

Element 18 — Date Signed
Enter the month, day, and year the PA/CADTA was signed (in MM/DD/YYYY format).

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